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MOBILIZING RESOURCES FOR THE MATCHING GRANT PROGRAM

The Matching Grant Program (MGP) was launched in 1999 with the central office of the Department of Health (DOH) playing a significant role in managing the program's resources. While the DOH's regional offices, known as Centers for Health Development (CHDs), identified the beneficiaries, the central office determined the amount of grants and the criteria for selecting beneficiaries.

With more municipalities and cities expressing interest in participating in the program, the CHDs were allowed to decide how much funding would be given to their respective local government units (LGUs). This flexibility maximizes the use of available MGP funds. The CHDs may also modify the criteria for selection and the standard memorandum of agreement to reflect local circumstances.

Two of the CHDs that are active in MGP expansion and are successful in mobilizing the necessary resources are the CHDs for Central Mindanao and Southern Mindanao, ably headed by Dr. Rogelio Chua and Dr. Dolores Castillo, respectively.

The Experience of the CHD for Central Mindanao

Central Mindanao, which has a population of 2.6 million, is composed of the provinces of Lanao Norte (22 municipalities), North Cotabato (17 municipalities), and Sultan Kudarat (12 municipalities). It has four cities: Cotabato, Iligan, Kidapawan, and Marawi.

Before 2001, only Kidapawan City was enrolled in the MGP. Through the persistent efforts of the CHD's staff, the number of MGP enrollees had ballooned to 31 by the end of 2001. Lanao Norte has 4 MGP sites, while North Cotabato and Sultan Kudarat have 12 each. In addition to Kidapawan City, the cities of Cotabato and Iligan also became MGP areas. To date, 32% of the region's population benefit from the MGP.

Funds for MGP implementation in Central Mindanao come from two sources: the CHD and the provinces (see Table 1). For 2001, the CHD allocated PhP3.2 million (US$64,000) for the enrollment of Cotabato City and 12 municipalities (4 in each of the 3 provinces), and the re-enrollment of Kidapawan City. Each grantee was allocated PhP250,000 (US$5,000) for the establishment of a community-based monitoring and information system (CBMIS) and the implementation of priority interventions, except Baroy in Lanao Norte, which received PhP220,000. Actual releases, as of December 2001, amounted to PhP1.3 million, or 40% of the total allocation.

Table 1. MGP Funds for 2001: CHD for Central Mindanao

Province	No. of LGUs	Source of Funds (in PhP)			
		CHD	Provincial Subgrant*	City*	TOTAL
Cotabato	13	1,250,000	1,600,000	-	2,850,000
Sultan Kudarat	12	1,000,000	1,600,000	-	2,600,000
Lanao Norte	4	720,000	-	-	720,000
Cotabato City	1	250,000	-	-	250,000
Iligan City	1	-	-	428,000	428,000
TOTAL	**31**	**3,220,000**	**3,200,000**	**428,000**	**6,848,000**

*Savings from the LGU Performance Program

Meanwhile, under the guidance of the CHD, the provinces also subgranted funds to selected municipalities for MGP implementation using their unutilized balance under the LGU Performance Program (LPP), the program that preceded the MGP. This is in line with DOH's Administrative Order No. 30, s.2001, which specified the guidelines for the implementation of the LPP for 2001-02. Both North Cotabato and Sultan Kudarat made available PhP1.6 million (US$32,000) for eight municipalities at PhP200,000 (US$4,000) each, while Lanao Norte used its balance to reproduce the CBMIS forms and conduct Phase I of the training on the MGP Technical Assistance Package (MGP-TAP) for its expansion areas. Iligan City was converted into an MGP area using its LPP savings of Ph428,000 (US$8,560).

Regardless of the source of funds, the LGU-beneficiaries were selected based on the following criteria: (1) population size, (2) LGU commitment or willingness to provide counterpart funds, (3) relationship among LGU health staff, (4) relationship between the LGU health workers and the local chief executive, and (5) performance of *Barangay* (Village) Health Workers. In choosing their subgrantees, provinces gave priority to hard-to-reach areas rather than to those with large populations.

Aside from fund management, the CHD also assumed increasing responsibility for conducting the MGP-TAP training for its LGUs. Assisting the CHD's four trainers is a core team composed of five DOH representatives, six Provincial Health Office personnel from Sultan Kudarat, and one from North Cotabato. Before this training took place, the CHD oriented the provinces and the CHD-funded LGUs on the objectives and mechanics of the MGP. The provinces conducted similar orientations for their respective subgrantees. The provinces also took the lead in negotiating with the local chief executives of the municipalities and in finalizing the memoranda of agreement.

For the CHD for Central Mindanao, its principal problems in implementing the MGP have been the inefficient procurement systems of LGUs and their slowness in releasing funds.

The Experience of the CHD for Southern Mindanao

The Southern Mindanao Region is composed of the provinces of Davao Oriental, Davao Sur, Davao Norte, South Cotabato, Sarangani, and Compostela Valley. Also located in the region are two independent cities, Davao and General Santos. As of January 2002, 39 of the 51targeted cities and municipalities in the region were officially enrolled in the MGP, or were able to put up counterpart funds, and the CHD had, therefore, already released funds to them.This number is expected to increase to 54 within the year as part of the expansion efforts of the CHD.

In the past, all enrollees received a uniform grant of PhP250,000 (US$5,000). Under its expansion phase, however, the CHD decided to provide its MGP enrollees grants ranging from PhP125,000 to 250,000 (US$2,500-5,000) to cover more LGUs. The amount varies depending on the population of the LGU and its need for additional resources. The grantees were selected based on the interest of the LGU, as demonstrated by its willingness to put up counterpart funds, as well as on the interest of the health workers in implementing the program. For 2001, the CHD budgeted PhP8.2 million (US$164,000) for the enrollment and re-enrollment of its LGUs in the MGP (see Table 2). As of December 2001, only 62% of the total amount had been released. Some LGUs were not given their allocation due to their inability to provide the required counterpart funds.

Table 2. MGP Funds for 2001: CHD for Southern Mindanao

Province	No. of LGUs	Source of Funds (in PhP)			
		CHD	Provincial Subgrant*	City*	TOTAL
Davao Oriental	5	750,000	-	-	750,000
Compostela Valley	11	1,650,000	-	-	1,650,000
Davao Norte	10	2,000,000	150,000	-	2,150,000
Davao Sur	6	1,000,000	125,000	-	1,125,000
South Cotabato	11	2,250,000	-	-	2,250,000
Sarangani	7	550,000	1,200,000	-	1,750,000
Gen. Santos City	1	-	-	1,000,000	1,000,000
TOTAL	**51**	**8,200,000**	**1,475,000**	**1,000,000**	**10,675,000**

*Savings from the LGU Performance Program

Augmenting the CHD's funds for MGP are the unutilized LPP funds of the provinces that were made available for MGP purposes. Among the provinces, only Sarangani had sizeable savings and was, therefore, able to subgrant PhP300,000 (US$6,000) each to four of its municipalities. Davao Norte and Davao Sur had only one subgrantee each. In addition, Davao Norte reproduced all the CBMIS forms for distribution to all MGP areas in the province. Meanwhile, Davao Oriental made available PhP10,000 (US$200) to each of its five municipalities and allocated funds for the reproduction of CBMIS forms for Phase I training. The Provincial Health Office purchased the equipment its non-MGP areas needed to meet the *Sentrong Sigla* (Center of Vitality) quality standards. General Santos City, a former LPP grantee, used its grant savings to undertake MGP activities.

Like other regions, Southern Mindanao has its share of MGP-related implementation problems. The problems mentioned by the CHD staff include: (1) failure of prospective enrollees to put up counterpart funds, (2) delayed signing of memoranda of agreement due to poor coordination between the Municipal/City Health Officer and the mayor, (3) delayed submission of final MGP plans by the LGUs, thus delaying the release of funds, (4) inability of trained health personnel to review the data gathered by volunteer workers, (5) slow fund utilization due to inefficient administrative procedures

and financial management at the LGU level, and (6) difficulty in monitoring the day-to-day implementation of the LGUs' work plans. In response to the last problem, the CHD made all DOH representatives accountable for the effective and timely implementation of the MGP in their respective areas by requiring them to submit monthly reports and review the LGUs' fund utilization reports, together with the Commission on Audit representative.

Lessons Learned

The experiences of the CHDs for Central and Southern Mindanao offer important insights into MGP implementation. First, the LGUs appreciate the financial as well as technical and in-kind assistance that the CHDs provide. The funds from the CHDs enable the LGUs to undertake health-related activities that could not otherwise be funded out of their regular budgets. Financial assistance is an effective and efficient way of supporting LGUs.

Second, most LGUs are willing to put up counterpart funds for the MGP, provided they are given the opportunity to reflect this in their budget proposal. Negotiations for MGP implementation should, therefore, be synchronized with the budget cycle of the LGUs.

Third, the CHDs are able to mobilize other resources to augment the LGUs' resources for health. The CHD for Southern Mindanao, for instance, uses part of its budget to support the renovation of health centers to facilitate their Sentrong Sigla certification. Moreover, regional discretionary funds may be used to support MGP expansion.

Fourth, the provinces are also potential sources of funds for the MGP. They could be encouraged to subgrant a portion of their funds to augment the resources of their constituent municipalities and cities. Allowing the provinces to adopt the subgranting mechanism is a way of building their capability to manage their own resources and honing their monitoring and supervisory skills. Being a funder itself, the province becomes more active in monitoring the LGUs' MGP activities and feels responsible for the performance of its LGUs.

Finally, inadequate financial management systems and bureaucratic red tape at the LGU level can delay the release of funds and hamper the implementation of planned activities, preventing the timely achievement of project objectives. Efforts should be made to improve the LGUs' administrative and financial procedures, particularly their procurement processes.

Future Initiatives to Enhance MGP Implementation in the Two Regions

For 2002, the CHD for Southern Mindanao allocated a total of PhP7.85 million (US$157,000) in MGP grants to 54 LGUs. Besides providing grants, the CHD for Southern Mindanao will carry out activities to assist the LGUs to achieve their project benchmarks by helping reduce their clients' unmet needs, particularly for family planning. For instance, the CHD will organize a regional surgical outreach team to perform bilateral tubal ligation among its indigenous people. Hand in hand with this, it will support the efforts of Davao Norte and Compostela Valley in organizing provincial outreach teams for voluntary surgical sterilization (VSS) by providing medicines and supplies and conducting community-based information, education, and information activities. The CHD, through the Davao Regional Hospital, will also strengthen its counseling and family planning services by participating in EngenderHealth's project on postabortion management and prevention of complications. It will help LGUs tap male community volunteer workers to promote male reproductive health, including sterilization and natural family planning. Finally, it will work towards mainstreaming natural family planning by expanding services through religious groups and other volunteers.

Meanwhile, using its PhP3.2 million MGP budget for the year, the CHD for Central Mindanao will re-enroll eight of the best performers from among its existing grantees as well as some of the best-performing subgrantees of the provinces. The CHD will also actively work for the Sentrong Sigla certification of the health facilities in its MGP areas by advocating among the local chief executives to support the upgrading of their health facilities to meet the prescribed quality standards, distributing relevant IEC materials, and helping the municipalities and cities obtain funds from the provinces and other stakeholders. Its advocacy efforts will include encouraging the local chief executives to enroll their indigents in the Indigent Program of the Philippine Health Insurance Corporation to enable them to access the inpatient and outpatient benefits available under the program. There are also plans to train the Barangay Health Workers to provide more health services, particularly home-based family planning services. Last, the CHD will provide technical assistance to the LGUs in their CBMIS computerization efforts to facilitate processing, analysis, and interpretation of data.

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